

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

v

File No. 122406-001-SF

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 15th day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On July 19, 2011, XXXXX authorized representative on behalf of his adult son XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation. The request was filed under Public Act No. 495 of 2006, MCL 550.1951 *et seq*, which authorizes the Commissioner to conduct external reviews for state and local government employees who receive health care benefits in a self-funded plan. Under Act 495, reviews are conducted in the same manner as reviews conducted under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on July 26, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on August 23, 2011.

Because medical issues were involved, the case was assigned to an independent review organization which provided its analysis and recommendations to the Commissioner on August 29, 2011.

II. FACTUAL BACKGROUND

The Petitioner received health care benefits through Medicaid for care provided through September 20, 2010. Effective October 1, 2010 he became a dependent on his mother's coverage through the State of Michigan and his health care benefits are defined in BCBSM's *Your Benefit Guide State Health Plan PPO* (the benefit guide).

On May 13, 2010 the Petitioner suffered a gunshot wound to the back of his head that resulted in right vertebral artery occlusion, right external artery occlusion, fractures of C2 and C3 with resultant quadriplegia, acute hemorrhagic shock and anoxic brain injury.) On June 3, 2010 following acute hospital care the Petitioner was admitted to a skilled nursing facility (SNF) and was discharged on February 16, 2011. At the time of his admission he did not have health coverage so Medicaid provided coverage through September 30, 2010.

BCBSM received a phone request for retro-certification¹. BCBSM denied the request that care in a SNF was not medically necessary as Petitioner could have been treated in an alternate setting. The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference on June 15, 2011, and issued a final adverse determination dated June 16, 2011 upholding its denial.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's care at a skilled nursing facility from June 3 through July 2, 2010?

¹ The June 16, 2011 final determination addresses the time period of June 3, 2010 through February 16, 2011. However, the Petitioner and BCBSM both assert that medical records beyond July 2, 2010 were not available for review. BCBSM only reviewed this time period and therefore, the Commissioner's review will also be limited to the period of June 3, 2010 through July 2, 2010.

IV. ANALYSIS

BCBSM's Argument

It is BCBSM's position that the need for skilled care must be established if a stay in a skilled nursing facility is to be covered. BCBSM states that while the Petitioner's injuries were severe, the care he received at the SNF could have been provided in an alternative setting such as an approved home health care program, private duty nursing program, or outpatient therapy program versus the inpatient hospital/facility setting.

BCBSM's medical consultants determined that Petitioner's inpatient setting was not medically supported by the medical documentation submitted for review and could have been provided in an alternate, non-skilled setting.

BCBSM maintains that its denial was appropriate.

Petitioner's Argument

In a letter dated June 23, 2011 the Petitioner's father argues BCBSM should have taken into consideration that Petitioner was already in XXXXX when his coverage became effective. He says:

When the insurance became effective BCBSM should have worked with me to get [Petitioner] home. The Head Nurse, Ms. XXXXX, at XXXXX did everything she could do to keep XXXXX from leaving by espousing information that the home care agency XXXXX did not want anything to do with [Petitioner] and that I was too old to care for [Petitioner] at home.

Plus, the doctors at XXXXX Hospital did not think that [Petitioner] could be care for at home. When I finally got a primary physician in place, the first thing the assistant to [Petitioner's] primary physician stated was that "You can't take care of him at home." This was in the Month of February of 2011 when [Petitioner] had gotten a lot stronger.

... I will submit the medical records but what bearing would the records have on your decision considering that [Petitioner] was already [in] XXXXX when the insurance became effective. It seems to me that rationality has escaped BCBSM when they came to the conclusion that they should have been contacted before [Petitioner] went to XXXXX.

In a letter dated May 24, 2011 Petitioner's father also says Petitioner was under contract #894880911 when he was injured on May 13, 2010. He says he did not know Petitioner was still

covered under his Wayne County contract.

The Petitioner believes that BCBSM is required to cover his stay at the SNF under his State of Michigan contract.

Commissioner's Review

The benefit guide excludes coverage for: "Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location." The benefit guide (p. 85) also defines a skilled nursing facility as:

A facility that provides convalescent and short or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. ...

The question of whether it was medically necessary for the Petitioner to receive care in a skilled nursing facility from June 3 to July 2, 2010 was presented to an independent review organization (IRO) for analysis as required by Section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer is board certified in internal medicine and has been in active practice for more than 18 years. The IRO report included the following analysis and conclusion:

The MAXIMUS physician consultant indicated that in order for the skilled nursing level of care to be medically necessary, a patient must require skilled nursing and/or skilled rehabilitation services on a daily basis, the services must be ones that, as a practical manner, can only be provided in a skilled nursing facility and there must be an expectation for practical improvement with realistic goals. The MAXIMUS physician consultant explained that at the time of his admission to the skilled nursing facility, the [Peticioner] had no specific skilled nursing or skilled rehabilitation needs. The MAXIMUS physician consultant also explained that the [Peticioner] could have received long-term care in an alternative setting with a home care program, private duty nursing program and outpatient therapy program. The MAXIMUS physician consultant indicated that there was no documentation demonstrating that skilled nursing facility level of care services were necessary as of 6/3/10.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that it was not medically necessary for the [Peticioner] to have been treated at a skilled nursing facility level of care from 6/3/10 to 7/2/10.

While the Commissioner is not required in all instances to accept the IRO's recommendation, it is afforded deference. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in this case.

The benefit guide also requires that a physician or skilled nursing facility also contact BCBSM for preauthorization. In Petitioner's case, according to BCBSM, XXXXX requested preauthorization December 17, 2010 for the period of June 3 through July 2, 2010. This was well after Petitioner was admitted as they were under the understanding that Petitioner did not have coverage.

Petitioner's father contends that he promptly "gave the BCBSM cards to XXXXX in October and never received anything regarding criteria." Under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether BCBSM properly administered health care benefits under the terms and conditions of the applicable insurance certificate and relevant state law. Resolution of factual disputes such as the one described by the Petitioner cannot be part of a PRIRA review because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM's denial of coverage for the June 3 through July 2, 2010 skilled nursing facility care was consistent with the terms of the certificate.

V. ORDER

BCBSM's final adverse determination of June 16, 2011, is upheld. BCBSM is not responsible for coverage of the skilled nursing facility care provided from June 3 to July 2, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in

the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner